STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005107	A. BUILDING: _____ B. WING _____	C 02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	1201 S MAIN ST CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00161743 Substantiated: No deficiencies cited. Date: 2-23/24-15 Facility Number: 005107 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Franciscan St Anthony Health-Crown Point is in compliance with 410 IAC 15-1.5-5, Medical Staff, Indiana Hospital Licensure Rules. QA: claughlin 03/06/15	S 000		